STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445476	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND HOME PARK HEALTH AND REHAB	1758 HILLWOOD DRIVE KNOXVILLE, TN 37920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were self-closing and, resist the passage of smoke and provided with a means suitable for keeping the door closed. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5:38 AM confirmed the dietary dishwashing room corridor door had 3 holes around to knob. 2. Observation and interview with the Maintenance Director, on 6/13/2016 at 5.58 AM confirmed 100 hall clean linen storage room door was not self-closing and was missing a middle hinge. These findings were verified by the Facilities	K 018	**Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** **taken:** K 018 — It is this facility's practice to ensure that corridor doors are self-closing, and resist the passage of smoke and provide a means suitable for keeping the door closed. A bid was received to replace the dietary dishwashing room corridor door and the linen storage room door, along with the hinges and hardware on 6/17/16, and the doors were ordered on 6/20/16. All other corridor doors that are self-closing were checked by the maintenance director 6/13/16 to ensure that they resist the passage of smoke and provide a means suitable for keeping the door closed and are in proper working order and free from holes/penetrations. 100% compliance noted for other doors. The doors needing replaced will be installed by 7/20/16. All corridor doors are checked monthly as part of the routine inspection schedule by the maintenance director or maintenance assistant.	7/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 6/30/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Supervisor and acknowledged by the Administrator during the exit conference on 6/13/2016.		**Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** **taken:**	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors were operable with no more than one releasing device. (NFPA 101-2000 Edition, 19.2.2.2.1 & 7.2.1.5.4) The findings include: Observation and interview with the Maintenance Director, on 6/13/2016 at 7:47 AM confirmed the electrical room door required 2 releasing motions to exit Door knob latch and deadbolt). This finding was verified by the Facilities Supervisor and acknowledged by the Administrator during the exit conference on 6/13/2016.	K 038	**K038** It is this facility's practice to ensure that doors are operable with no more than one releasing device. The internal bolt was removed from the deadbolt on the electrical room door on 6/16/16 by the maintenance director. All other doors within the facility were checked by maintenance personnel to ensure that there was not more than one releasing device on 6/16/16. No others doors found to have more than one releasing device.	6/16/16
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure combustible decorations were not highly flammable (NFPA 110, 19.7.5.4). The findings include: Observation, interview, and record review with the Maintenance Director, on 6/13/2016 between	K 073	**Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** **taken:**	

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K 073	Continued From page 2 5:57 AM and 7:45 AM confirmed the facility failed provide documentation decorations (door wreaths) were fire retardant or were treated with fire retardant material. This finding was verified by the Facilities Supervisor and acknowledged by the Administrator during the exit conference on 6/13/2016.	K 073	It is this facility's practice to ensure that all combustible decorations are not highly flammable. All door wreaths/decorations were treated with fire retardant material and documentation completed initially on 6/15/16 maintenance director and housekeeping technician. All items treated with the fire retardant material will be tagged and logged to demonstrate compliance. This will be completed by 7/1/16 by maintenance director, maintenance assistant, or housekeeping technician. New admissions to the facility will be informed in writing during the admissions process by the person completing admissions that any door decorations/wreaths will need to be given to the maintenance department for treatment and will be tagged and logged at that time. A letter reminding resident and family members that all decorations must be inspected and treated with fire retardant, and properly tagged and logged has been drafted and will be mailed to each responsible party. Maintenance director, maintenance assistant or housekeeping technician will audit resident's doors for decorations to ensure that items have been treated and tagged five times per week for one month, then weekly X 3 months.	7/1/16
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 80, 2010 edition states: 5.2.4.2 As a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly			

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K 130	Continued From page 3 have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. 4.8.4.1 The clearance under the bottom of a door shall be a maximum of 3/4 in. 6.3.1.7.1 The clearances between the top and vertical edges of the door and the frame, and the meeting edges of doors swinging in pairs, shall be 1/8 in. ± 1/16 in. for steel doors and shall not exceed 1/8 in. for wood doors. Based on observation and interview, the facility failed to maintain fire doors. (NFPA 101, 19.7.6, 4.6.12.1, 8.3.3.1, Table 8.3.4.2, NFPA 80 2010 edition, 5.2.4.2) The findings include: 1. Record review and interview with the Maintenance Director, on 6/13/2016 at 1:55 PM confirmed the facility failed to conduct annual fire door inspections. (NFPA 101 (2010 edition)18/19.7.6 & 4.6.12.1; NFPA 80 (2010 edition) 5.2.1) 2. Observation and interview with the Maintenance Director, on 6/13/2016 at 6:02 AM confirmed the fire doors by rooms 401/402 were missing 6 hinge screws. 3. Observation and interview with the Maintenance Director, on 6/13/2016 at 7:45AM confirmed the laundry room 1-1/2 hour rated fire door has 11 holes in the frame and 27 holes in the door where door closers had been changed repeatedly.	K073	Results of these audits will be presented to the Quality Assurance Performance Improvement (QAPI) committee meeting monthly for 3 months. The QAPI committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Director, Social Services, Staff Development Coordinator, Activities Director, Dietary Director, and Environmental Service Director. **Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** **taken:**	
		K130	It is this facility's practice to ensure that the fire doors are maintained. Annual fire door inspection will be completed by the maintenance director by 7/15/16. Annual inspections will be maintained by the maintenance director. The six missing hinge screws on the fire doors by rooms 401/402 were replaced on 6/21/16.	7/15/16

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K 130	Continued From page 4 These findings were verified by the Facilities Supervisor and acknowledged by the Administrator during the exit conference on 6/13/2016.	K 130		